City of Milpitas

PERMISSION, RELEASE AND WAIVER OF LIABILITY

In consideration of my child, (name of child)_____ being permitted to participate in the following activities (name of activities)_____on (dates)_____("Activities") of the (name of program)_____, I hereby agree to the following:

1. I understand that the Activities may involve the risk of injury. I, on behalf of my child, myself and my heirs, assigns, representatives and next of kin hereby RELEASE, WAIVE, DISCHARGE AND AGREE NOT TO SUE the City of Milpitas, its elected officials, officers, employees and agents ("Releasees") for any loss or damage arising from my child's injury or death, whether caused by the negligence of the Releasees or otherwise while my child participates in the Activities (including travel to or from such Activities), regardless of the location of the loss or damage.

2. I understand that my child has (name of medical condition)_____. I hereby consent to City personnel administering an Epi-Pen injection to my child in the event of emergency. I agree to provide such Epi-Pen and all materials necessary to administer the Epi-Pen to City personnel.

3. The undersigned TAKES FULL RESPONSIBILITY for, and ASSUMES THE RISK of, any loss or damage arising from my child's injury or death, whether caused by the negligence of the Releasees or otherwise.

4. I also GRANT PERMISSION to any Releasee to seek medical help from any licensed hospital for my child in the event of an accident or illness.

The undersigned further expressly agrees that this Permission, Release and Waiver of Liability Agreement is intended to be as broad and inclusive as is permitted by California law. If any portion of this agreement is held by a court of proper jurisdiction to be invalid, it is agreed the remainder of the agreement shall continue in full force and effect. This agreement is the whole agreement and no oral representations are a valid part of this agreement.

I HAVE READ AND AGREE TO THIS RELEASE AGREEMENT

Parent

_____ _____ _____

(sign) (print name) (phone number)

Date:_____

Name of physician:_____ phone #:_____

Medical Insurer: _____ policy #:_____